Applicant's SSN (from Page 1, Section I) ☐☐☐-☐☐-☐☐☐☐

SECTION V: CUSTODIAL PARENT INFORMATION

Dependent(s) listed that do not live with you may only be covered if the employee (or spouse) has a court or administrative order requiring insurance coverage for health care expenses of the child. Coverage provided due to a court or administrative order may not be terminated without proper documentation.

Dependent's Social Security Number

☐☐☐-☐☐-☐☐☐☐

☐☐☐-☐☐-☐☐☐☐

Custodial Parent Name _____ All Dependents? ☐< Yes

Custodial Parent Address _____ Country / Mail Code (If not U.S.A.) _____

SECTION VI: FLEXIBLE SPENDING ACCOUNT

I understand that enrollment is OPTIONAL and that by completing this section, I am enrolling in a Flexible Spending Account.

Health Care Spending Account

Maximum allowable combined contribution per employee is $120 per paycheck
Minimum allowable combined contribution per employee is $5 per paycheck

Employer Contribution per paycheck: $ _____.

Participant Contribution per paycheck: + _____.

Sub-Total per paycheck: $ _____.

Number of expected paychecks: X _____

Total Contribution for Plan Year: $ _____.

Dependent Care Account

TAX FILING STATUS **(Check One):**

☐ < **Married, filing separately** (max - $104.00 per paycheck)

☐ < **Married, filing jointly** (max - $208.00 per paycheck)

☐ < **Single, head of household** (max - $208.00 per paycheck)

Minimum - $5.00 per paycheck. Maximum as indicated above.

Participant Contribution per paycheck: $ _____.

Number of expected paychecks: X _____

Total Contribution for Plan Year: $ _____.

EZ Reimburse Card ☐ *< I decline enrollment in the EZ Reimburse Debit Card plan.*

I understand that if I do not decline, I will be enrolled in this plan. I understand that there is a $6 annual fee and a $0.50 charge per transaction.

SECTION VII: AUTHORIZATION AND CERTIFICATION

* My signature below certifies that I understand the statements on this form are true and complete to the best of my knowledge.
* I understand that all benefits for myself and my eligible dependents will be provided in accordance with the plan contract.
* I agree to abide by the terms and the conditions governing membership and receipt of services from the plan in which I have enrolled.
* I understand that the misrepresentation of any information on this application with the intent to defraud is a fraudulent insurance act, which is a crime, and any material misrepresentation or omission may be used to reduce or deny a claim or void the contract.
* I understand that the selections indicated on this enrollment form may not be changed or canceled during the year of coverage with the exception of certain Qualifying Events.
* I authorize my employer to deduct from my earnings the amount required to cover my share of the coverage I have selected.
* I elect to participate in the Premium Conversion Program unless I sign the cancellation form. [For more information on Premium Conversion, see the Health Insurance Handbook.]
* Regarding my Flexible Spending Account, I hereby authorize my employer to reduce my gross salary before Federal, State, and Social Security taxes are calculated by the total amount of Participant Contribution indicated above.
* Regarding my Flexible Spending Account, I understand that the contribution to my Social Security Account will be reduced since participant contributions will be based on my income after reductions.
* Regarding my Flexible Spending Account, I further understand that any unused amount remaining in my Spending Account at the conclusion of the plan year cannot be carried forward to the next year due to I.R.S. regulations.
* My signature below certifies that I have read both the Health Insurance and Flexible Spending Account Handbooks and agree to be bound by their terms and conditions. All information listed on this application was completed with knowledge of the Handbooks' terms and conditions, and I accept full responsibility for any deficiency concerning my application due to a failure to conform to the Handbooks' terms and conditions.

_____ _____

Employee Signature Date

_____ _____

Spouse Signature Date

(***Only REQUIRED if applying for a cross-reference plan)***

I understand that any person who knowingly, and with the intent to defraud any insurance company or other person, files an application for insurance containing any forged signature or incorrect signature date thereto commits a fraudulent insurance act, which is a crime. I understand that I can be held responsible for any fraudulent act that is the result of a forged signature or incorrect signature date that I could have prevented while acting within my duties related to the state-sponsored health insurance plan. My signature below certifies that all signatures and signature dates affixed to this contract are correct to the best of my knowledge.

_____ _____

Insurance Coordinator Signature Date

_____ _____

Signature of Spouse's Insurance Coordinator Date

(***Only REQUIRED if applying for a cross-reference plan)***